year or two and then went home. They make little or no contribution to the health of the country and in fact do harm by suggesting to the indigenous junior doctors that such gadgets are important for the practice of good medicine. They are part of the hidden curriculum described by Dr David Morley, which exerts such a powerful and harmful influence on young doctors to encourage them to practise high technology medicine inappropriate to their nation's needs. The true beneficiary of such service abroad is the doctor himself, who usually manages to publish a paper or two about his African patients.

Developing countries need doctors prepared to go to areas where there is a shortage of doctors to practise relatively simple medicine. Two years is probably the minimum period that is really useful. It takes at least that long to shake off the high technology attitudes ingrained by a traditional medical training.

Perhaps appointment committees should give some consideration to the usefulness of a candidate's work abroad. After all a doctor who provided care appropriate to the real needs of people in developing countries might also be the one who will provide the most appropriate health care in Britain.

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Reduced sinus arrhythmia in diabetic autonomic neuropathy

SIR,—Dr W Wieling and Dr C Borst (5 February, p 476) have drawn attention to an interesting aspect of testing for autonomic neuropathy in diabetes using measurement of heart rate variations on deep breathing. We described a single breath test in which the shortest R-R interval during inspiration (I) and the longest during expiration (E) are measured to obtain the E:I ratio (4 December, p 1599). This ratio declines with age and is independent of resting heart rates below 100 beats/minute. Dr Wieling and Dr Borst recommend taking the E-I difference averaged from six consecutive respiratory cycles. We have shown, however, that this measure depends on both age and baseline heart rate and so must be used with a normal range that accounts for both of these variables.[1]

We have compared the repeatability of both the E:I and the E-I from single and repeated breath tests in 20 healthy subjects (mean age 40 years, range 20-87 years) measured at two separate visits, 3-8 months apart (see table).

Repeatability of different methods of analysing sinus arrhythmia

	E-I	E:I
Single breath (first of five cycles)	28·6%	8·9%
Average of five consecutive cycles	21·9%	6·3%

Values are the coefficients of variation of the within subject variance.

There is a clear advantage in taking the ratio since it is independent of differences in resting heart rate occurring between tests.

The repeatability of the averaged values was slightly better than the single breath. We do not consider, however, that this small improvement is great enough to justify the more cumbersome repeated breath test when screening for autonomic dysfunction in a busy diabetic clinic.

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Ventilation in operating rooms

SIR,—The letter from Dr J K Wardle and others (12 February, p 557) detailing their use of prophylactic antibodies in neurosurgery cannot be allowed to pass without comment. Surely it is now accepted that prophylactic antibodies must be in the tissues before organisms are innoculated into the wound.[1] It is at best inefficient and may well be useless to start prophylactic treatment, as they have done, when the patient returns to the ward after surgery. Similarly, there is no good evidence to show that continuing the antibiotics after surgery is of any benefit.[2,3] Prophylactic antibiotics clearly have a place in all branches of surgery, but it is important that they are used correctly.

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High calorie supplements for patients with anorexia nervosa

SIR,—Until recently there has been a rather prominent loophole in the options available for the treatment of anorexia nervosa. To admit a patient with anorexia nervosa to hospital is a major step, and the resultant difficulties between doctor, patient, nurses, and relatives can be extremely disruptive. Despite repeated family tuition about high calorie foodstuffs the end result of outpatient treatment is often just as disastrous.[1]

Refeeding often requires admission to hospital with feeding regimens supervised by a dietitian,[2] and vigorous refeeding has resulted in acute pancreatitis, acute gastric dilatation and duodenal ileus,[3] hypophosphataemia,[4] gastric rupture, and gangrene of the stomach.[5]

I have found that high calorie supplements are a painless and easily monitored way of dealing with the outpatient care of this illness. If, in addition to being readily available, the supplement were palatable and acceptable to a patient with anorexia nervosa it would provide a handy form of management at surprisingly low cost. Unfortunately, these supplements are borderline substances and they have not been available on prescription except for certain defined conditions. The non-availability may be used by patients to reinforce their resistance to taking any food which may put weight on at a more rapid rate than they would like.[6]

As a result of a letter published in the *BMJ*[6] I was approached by the Department of Health and Social Security, and, after submitting evidence, I received a letter informing me that the DHSS had agreed that Clinifeed, Ensure, Ensure Powder, Ensure Plus, Flexical, Forceval Protein, Isocal, Triosorbon, and Vikonex should be available on prescription for treating patients with anorexia nervosa. Caloreen and Hycal are not included.

I hope that this will serve as a stimulus to the pharmaceutical industry to produce cheap, palatable, high calorie, low volume foodstuffs, available on prescription for treating patients with anorexia nervosa as outpatients. Further work on this neglected area is underway in our department.

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Responsible use of resources: day surgery

SIR,—I warmly welcome the proposals and views expressed by Dr J M B Burn (5 February, p 492) concerning the value of day surgery and would like to add my own experience of treating patients referred to a plastic and reconstructive surgical department in a district hospital.

Three years ago a 14 bedded ward vacated by enforced bed closures in this hospital was converted into a day surgery unit. In 1981 I treated 571 patients in the main theatre and 566 in the new day surgery unit. For 1982 numbers were 541 and 541 respectively. In other words Dr Burn's suggestion that half of most surgery could be managed on a day basis applies to the specialty of plastic surgery. The range of procedures include: excision of benign and certain malignant skin tumours with direct closure, local flaps, or skin grafts; scar revisions and dermabrasions; excision of tattoos; surgery of axillary hyperhidrosis; limited palmar-digital fasciectomy; synovectomy of hand joints; peripheral nerve decompressions; nail bed resection and digital amputations; tenolysis and release of trigger finger; correction of prominent ears; penile meatoplasty; minor rhinoplasty; capsulotomy after breast reconstruction; and nipple and areolar reconstruction after mastectomy.

Apart from the obvious advantages to the patient, the surgical waiting lists, and the district economy, day surgery provides good training ground for student nurses or maturer nurses returning to hospital work. In one department they have an opportunity to follow the patient from admission, into the theatre, the recovery area, discharge, and to subsequent change of dressings or suture removal. Furthermore, the team spirit generated in a small autonomous unit leads to a happy unit—working in day surgery can be fun.

The practice of day surgery, however, implies a change of surgical tradition and habit. Although this system has been widely